

Initiating insulin in type 2 diabetes: collaboration or coercion?



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Supplement Editor

Diabetes affects morbidity and mortality in elderly people. This is likely to become an even greater health problem given the growing ageing diabetes population (Haq et al, 2003). Transferring elderly people with type 2 diabetes to insulin has become the norm rather than the exception as healthcare professionals strive to meet targets. Is this what our elderly patients need or want? Do they have a choice in the decision-making process and does anyone listen anyway?

Power for whom?

Anderson (1995) argues that most physicians are trained to think about diabetes in terms of managing blood glucose levels. In addition, many healthcare professionals end up trying to direct the daily conduct of their patients' lives in the same way that parents direct their children. However, many people with type 2 diabetes are unable or unwilling to carry out the difficult and often unrealistic recommendations they are given. In diabetes, there is very little that is more complicated than starting insulin therapy especially for an elderly person. Do we really give them a choice and if we do, how do we go about it?

Jewell (1996) found that elderly people adopt a subservient role in exchanges with medical and nursing staff. Decisions regarding daily medication and nursing management are rarely discussed with the patients. There is no doubt that doctors need power in order to fulfil their professional obligations. Goodyear-Smith and Buetow (2001) believe that patients also need power to formulate their values, articulate and achieve their health needs and fulfil their responsibilities. The balance of power lies midway between doctors making decisions without the input of the patient, or offering information for the patient to become the sole decision-maker (Mead and Bower, 2000). Glynn and Elwin (1999) argue that the balance of power still tends to favour the doctor.

Not what the doctor ordered!

Improving metabolic control is likely to affect

psychological well-being. Assessment and education must be recognised as key areas of management in older patients if improvements in healthcare are to be achieved (Allwinkle, 1997). Standard 3 of the NSF for Diabetes tells us to 'encourage partnership in decision-making' in order to empower people with diabetes (DoH, 2001). Empowerment is an integral part of health. Madder (1997) suggests that we should encourage patients to make their own choices as a manifestation of their autonomy. However, as healthcare professionals we need to be aware that patient choices may have outcomes that oppose what we believe is right.

Anderson (1995) points out that diabetes care is a complex mesh of social, emotional, cultural, psychological and demographic fabric woven into the patient's life. Expertise in blood glucose control is one element of this. Healthcare professionals have an ethical responsibility to put the patient's needs and interests first. We need to consider all of these aspects, discuss them with the patient and come to a mutual decision for the benefit of that individual. Patients require information, but we need to be careful that the manner in which we deliver such information is not so laden with our own values that it coerces our patients into making a decision they are unhappy with. We need to think carefully before transferring elderly people to insulin. Do they really need it? Will it improve their quality of life or are we just chasing targets?

Conclusion

There is no doubt that for some elderly patients insulin is a necessity. Many cope extremely well once they have mastered the practicalities of their new regimen. However, for others insulin causes disruption and anxiety and does little to improve their lives. Before initiating insulin therapy in our elderly population we need to make absolutely sure that this is the right course of action, that we have patient collaboration and that we have not achieved our aim by coercion. ■

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